

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

33412

9540

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No.

1. PLACE OF DEATH:

(a) County **St. Louis**  
(b) City or town **4117 Botanical**  
(c) Name of hospital or institution **4117 Botanical**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Emma C. Owings**

3. (b) If veteran, name war **None**  
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife **J.W. Owings** 6. (c) Age of husband or wife if alive years **3** 1862  
7. Birth date of deceased **May** (Month) (Day) (Year)

8. AGE: Years **81** Months **5** Days **26** If less than one day hr. min.

9. Birthplace **Mexico, Missouri** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **T.M. Northcutt**

12. Name **Bowling Green** 13. Birthplace **Missouri** (City, town, or county) (State or foreign country)  
14. Maiden name **Marie Jane Johnston**  
15. Birthplace **Columbia, Missouri** (City, town, or county) (State or foreign country)

16. (a) Informant **Harry W. Owings**  
(b) Address **4555 Shenandoah**

17. (a) **Burial** (b) Date thereof **Oct. 30, 1943** (City or town) (County) (State)  
(c) Place: burial or cremation **Pisgah Cem. Sturgeon, Mo.**

18. (a) Signature of funeral director **W. J. R. L. & Co.**  
(b) Address **1905 South Grand, St. Louis**

19. (a) **OCT 30 1943** (b) **J. F. Bredek** (Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **4117 Botanical** (If outside city or town limits, write "RURAL")  
(d) Street No. **St. Louis, Mo.** (If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **29** year **1943** hour **7** minute **5** AM

21. I hereby certify that I attended the deceased from **Sept 23, 43** to **Oct 29, 43**  
that I last saw her alive on **Oct 28, 43** and that death occurred on the date and hour stated above.  
Immediate cause of death **Chronic Myocarditis** Duration **4 1/2** years

Due to **Arterio-sclerosis**

Due to **None**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **None**

Of autopsy **No**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **No**  
(b) Date of occurrence **No**  
(c) Where did injury occur? **No** (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **No**

While at work? (Specify type of place) (e) Means of injury

23. Signature **W. J. R. L. & Co.** (M. D. or other)  
Address **1460 South Grand** Date signed **1943**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

---

---

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*John J. Fetter*

Licensed Embalmer No.....

*3880*

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**